

# ON IVAN ILLICH AND *THE LIMITS TO MEDICINE*



Reflections on the Man and his  
*Medical Nemesis: The Expropriation of Health*

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### Reflections on the Man and his *Medical Nemesis: The Expropriation of Health*

Reading Ivan Illich is not easy, though in a different way to reading Continental philosophers, quantum physicists, or modern virologists. Illich's language is demanding and requires a certain suspension of judgement if one is to penetrate the systemic meaning behind his often challenging – if not vehement – rhetoric. But it is worth the effort.

It is difficult to appreciate the nature of Ivan Illich's critique of Western society and of modernity in general without having some familiarity with his early experiences. He was born in 1926 to a Dalmatian father of landed aristocratic birth and a German mother of Sephardic ancestry whose family had converted to Catholicism. He knew privilege from an early age. Rainer Maria Rilke, Jacques Maritain and Rudolf Steiner were all visitors to his family home.

Illich moved to Vienna in the early 1930s with his mother and his younger twin brothers. They soon came to experience the heaviness of the Nazi regime at close range, particularly after the annexation of Austria in 1938. In order to avoid Nazi persecution, they moved once again in 1941, re-settling in Florence. Those early years taught Illich how suddenly one's life and cultural circumstance can change. As a child, he had known the steadiness and stability of his father's ancestral culture, yet because of his mother's heritage, within a few short years he had come to experience the fragility of many of life's "certainties."

When he was 12 years old, Illich had a foreboding about what was soon to erupt throughout Europe. While walking on the outskirts of Vienna just before the Nazi invasion, he decided that he would never marry because,

*certain things will happen which will make it impossible for me to give children to those towers down on the island in Dalmatia where my grandfathers and great-grandfathers made children.<sup>1</sup>*

By the age of 17 years, he had resolved to enter the priesthood. He studied philosophy and theology at the Jesuit-run Gregorian Institute in Rome and concurrently undertook a doctoral thesis at the University of Salzburg based on a study of the ideas of Arnold Toynbee. While in Rome, Illich was drawn into a number of influential circles and developed a personal friendship with his old family friend, Catholic philosopher Jacques Maritain. Through Maritain, he was introduced to Cardinal Giovanni Montini, who was later to become Pope Paul VI.

Illich completed his studies and was ordained a priest in 1951. His intellectual power had been noted by Montini who wanted him to join the Vatican inner circle. The Cardinal urged him to enrol at the *Accademia dei Nobili Ecclesiastici* in Rome. Illich, however was more interested in history and planned for a second doctoral degree at Princeton University.<sup>2</sup> He crossed the

<sup>1</sup> Cited in James Arraj: *In Search of Ivan Illich*. Viewed at: <http://www.innerexplorations.com/chtheomortext/illich.htm>

<sup>2</sup> Todd Hartch (2015): *The Prophet of Cuernavaca. Ivan Illich and the Crisis of the West*, Oxford University Press, p. 6

Atlantic soon after and was appointed parish priest of an impoverished Puerto Rican community in New York.

For the next 5 years, Illich was fully immersed in Puerto Rican life and culture. Apart from serving the needs of his own parishioners, he visited Puerto Rico at every opportunity, often travelling on horseback. It was there that he began to regain a sense of the stability and resilience of traditional communities, something that had been shaken by his experiences in Austria. Illich's time with Puerto Ricans also reinforced a growing distaste for modernity with its wanton destruction of traditional cultures. The themes of cultural integrity and resilience were to be interwoven into his wide-ranging intellectual explorations thereafter.

Illich's unique qualities were quickly recognised. By 1956, he had been appointed Vice-Rector of the Catholic University of Puerto Rico where he established a facility that introduced American priests and religious to the language and the cultural life of Latino communities. He also became deeply interested in the schooling of the local children. It was in Puerto Rico that the ideas for what would eventually find expression in *Deschooling Society* a decade later began to take form.

In his role as Vice-Rector at the University, Illich managed to cross swords with both of the Catholic bishops of Puerto Rico. His situation eventually became so untenable that he resigned from his post. On returning to New York in 1960, he was enthusiastically welcomed by the *Centre of Intercultural Formation* at the Jesuit Fordham University, which was at that time looking to establish a training program for missionaries in Latin America.

Illich was appointed executive director of the new program for a five-year period and given generous funding to set it into motion. He took to the road in search of a suitable base. For the next four months, he ranged throughout Latin America, often travelling by bus or hitch-hiking in order to more fully participate in the life-worlds of local communities.

On arriving in Cuernavaca near Mexico City, he met with Mendez Arceo, a courageous and open-minded bishop, "who had a transformative and renewed vision of the Church quite different from official church positions."<sup>3</sup> They hit it off immediately and Illich there and then decided to establish the *Centro de Investigaciones Culturales* (CIC) at Cuernavaca. The first missionaries began to arrive in 1961. Bruno-Jofre offers the following reflection:

*Cuernavaca was the right place for Illich. It had been a field of Catholic experimentation before Vatican II, under the leadership of Bishop Mendez Arceo. . . . It was a special place in which the local Church as an institution had attempted to engage with the spirit of the times and with the people themselves, even before Vatican II.*<sup>4</sup>

Illich soon gathered a group of influential teachers around himself. Under his stewardship, the CIC in Cuernavaca rapidly established itself as a centre of far-ranging intellectual engagement.

Three years later, Illich established a parallel centre in the same premises, the *Centro*

<sup>3</sup> Bruno-Jofre, Rosa and Zaldiva, Jon Igelmio (2016): *Monsignor Ivan Illich's Critique of the Institutional Church, 1960-1966*, J. of Ecclesiastical History, vol. 67, 3, pp. 568-586. Available online at: <https://www.cambridge.org/core/journals/journal-of-ecclesiastical-history/article/monsignor-ivan-illichs-critique-of-the-institutional-church-19601966/68381ED8A562701016B13BC4868E57FB>

<sup>4</sup> Ibid., p. 577

*Intercultural de Documentacion* (CIDOC), an entity that was completely independent of Church funding. By 1965, CIDOC had virtually subsumed CIC's role. Through CIDOC, Ivan Illich and his collaborators began to project powerful, independent and controversial ideas that challenged conventional thought in many disciplines.

The establishment of the CIC had been a response to calls from conservative Catholic elements in the US and from Pope John XXIII for the "modernisation" of Latin America through missionary activity. The clerics, religious and volunteers who arrived at the CIC in Cuernavaca found, however, that,

*something very different was being offered. Instead of teaching words of a new language they learned to be quiet; and instead of basic notions about Latin American culture they [CIC] dissuaded missionaries from achieving their goal.*<sup>5</sup>

Catholic support for the Fordham project had been largely motivated by concern over the perceived growth of both Marxism and Protestantism in Latin America. Castro's success in Cuba prompted John F. Kennedy to launch the *Alliance for Progress*, a ten-year multi-billion-dollar aid program on August 17<sup>th</sup> 1961. Curiously, that same day, Pope John XXIII formally instructed the North American Catholic hierarchy to send missionaries and lay volunteers in large numbers to Latin America.<sup>6</sup>

Illich was aware that the priests and lay missionaries attending Cuernavaca could, without their knowing it, inadvertently find themselves in the service of imperial power. He strove to sensitise them above all to the culture of the communities within which they would be working. His concerns were later to be made explicit in one of Illich's more controversial papers, *The Seamy Side of Charity* published by the Jesuit weekly *America Magazine* in January 1967. In it, he wrote:

*The men who go to Latin America must humbly accept the possibility that they are useless or even harmful, although they give all they have. They must accept the fact that a limping ecclesiastical assistance program uses them as palliatives to ease the pain of a cancerous structure. . .*

*We must acknowledge that missionaries can be pawns in a world ideological struggle and that it is blasphemous to use the gospel to prop up any social or political system.*<sup>7</sup>

Illich was deeply conscious of the movements that were arising spontaneously among the people of Latin America. By the time that Cuernavaca was established, he had spent close to a decade living close to Latinos, firstly in New York, then at the Catholic University in Puerto Rico, and more recently, on the streets and in the barrios of Central and South America. His contact with Bishop Mendez Arceo had affirmed the existence of a strong and engaged Catholicism in Latin America that was beginning to find its own unique expression.

Not surprisingly, word of Illich's activities at Cuernavaca began to reach the ears of more conservative members of the Catholic hierarchy, both locally and in the US. One of the local

<sup>5</sup> Zaldivar, Jon Igelmo and Uceda, Patricia Quiroga, (2011), *Ivan Illich and the Conflict with The Vatican (1966-1969)*, The International Journal of Illich Studies, Vol. 2, 1, pp. 3-12, p. 3, Available online at: <https://journals.psu.edu/illichstudies/article/view/59274/58999>

<sup>6</sup> Bruno-Jofre and Zaldiva, op. cit., p. 574

<sup>7</sup> Illich, Ivan (1967): *The Seamy Side of Charity*, America. The Jesuit Review, Jan.21, 1967. Viewed at: <https://www.americamagazine.org/issue/100/seamy-side-charity>

bishops even accused him of sorcery.<sup>8</sup> Despite the support of Bishop Arceo in Mexico and Cardinal Spellman in New York, Illich was ordered to present himself before the Vatican's *Congregation for the Doctrine of the Faith* in 1967. He arrived in Rome in June 1968 and maintained a dignified reserve in the face of accusatory questions regarding his own activities and those of his religious and academic colleagues in Mexico. In January 1969, the Vatican instructed the Bishop of Cuernavaca that priests and religious were thenceforth to be prohibited from participating in any of the programs or activities at CIDOC.

Illich resigned from his priestly ministry two months later in March 1969. He never, however, lost his connection with the deeper spirit of Catholicism and what he referred to thereafter as *Mother Church*. He remained celibate and continued to recite the divine office daily for the rest of his life.

Having formally put aside his monsignorial role, Illich immediately embarked upon a highly energised and productive phase of his life, publishing four books – each of which was widely read – between 1970 and 1975. Though thematically different, each of these publications offered radical critiques of the cultural developments that Illich and his colleagues had examined at Cuernavaca. The last of these works was entitled *Medical Nemesis. The Expropriation of Health*. It offered a highly individuated and revolutionary critique of the personal, social and cultural influence of Western technological medicine.

*Medical Nemesis* was a work of deep scholarship, fluid erudition, and fearless rhetoric. It unapologetically laid bare the excesses and the deficiencies of a profession that had over the previous century claimed immense cultural authority for itself. Illich's earlier published books were largely collections of essays. *Medical Nemesis* however, was a tightly integrated and wide-ranging review of the expropriation of individual and cultural autonomy by the profession of medicine.

Illich clearly understood the magnitude of what he was taking on. Unlike his earlier works, *Medical Nemesis* was extensively foot-noted with sources ranging from *The Lancet* and *The New England Journal of Medicine* to the works of Montesquieu and Wittgenstein. By the end of the second chapter of this eight-chapter book, Illich had already referred to the writings of such medical commentators as Rene Dubos, Thomas Szasz, Michael Balint and Maurice Pappworth, sociologists including Eliot Friedson and Howard Becker, and philosophers and cultural historians including Simone de Beauvoir, Michel Foucault, Eric Voegelin and Lewis Mumford.

By documenting the sources of his ideas and insights with such thoroughness, Illich hoped that his non-medical readers would begin to look at what was already out there for themselves. He also wanted to leave a well-signposted audit trail for those within the medical profession who he knew would be incensed by what he presented. Predictably, *Medical Nemesis* was not welcomed by most within the medical fold. But Illich was no stranger to the consequences of truth-speaking. He had been forced out of his own church by criticising the policies of the Roman curia and of North American prelates in the management of Central and South American "problems." Ivan Illich had a penchant for rocking the boat. Not surprisingly, he found himself cast adrift.

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<sup>8</sup> Zaldivar and Uceda (2011), op. cit., p. 6

In *Medical Nemesis* Ivan Illich identifies and deconstructs many of the unconscious elements behind the biomedical enterprise. He draws attention to the complicity of biomedicine in *enabling* people to adapt to inherently sickening social, industrial, environmental and political realities:

*The physician, himself a member of the dominating class, judges that the individual does not fit into an environment that has been engineered and is administered by other professionals, instead of accusing his colleagues of creating environments into which the human organism cannot fit.*<sup>9</sup>

At a more concrete level, Illich brings to light the limitations of biomedicine's mechanistic and reductionistic view of life, and urges a reconsideration of vitalistic and holistic perspectives that encompass more fully the nexus within which both health and sickness arise. He draws strongly from historical and cultural frames that place the individual within meaningful contexts from which the slings and arrows of adverse fates, the reality of human debility and limitation, and the inevitability of suffering and death can be negotiated. Much of his ferocity is directed against the medicalisation of all stages of life, and especially of death:

*For rich and poor, life is turned into a pilgrimage through check-ups and clinics back to the ward where it started. Life is thus reduced to a "span," to a statistical phenomenon which, for better or for worse, must be institutionally planned and shaped. This life-span is brought into existence with the pre-natal check-up, when the doctor decides if and how the foetus shall be born, and will end with a mark on a chart ordering resuscitation suspended.*<sup>10</sup>

Illich writes at length of iatrogenesis – of the illness or injury caused by medical interventions – but extends the field of inquiry far beyond the domain of personal incidents into the broader theatres of social and cultural consequence. *Social* iatrogenesis is made manifest in the medicalisation of all aspects of life and the subsequent loss of individual autonomy and capacity for self-care by citizens who are transformed into "patients." Of greater concern to Illich is the *cultural* iatrogenesis reflected in a near-total abandonment by Western societies of the traditional resources, understandings and philosophies that have perennially enabled people to cultivate the art of suffering, and to accept - if not embrace - this inevitable and inescapable dimension of human life and experience. He writes:

*Traditional cultures and technological civilization start from opposite assumptions. In every traditional culture the psychotherapy, belief systems, and drugs needed to withstand most pain are built into everyday behavior and reflect the conviction that reality is harsh and death inevitable. In the twentieth century dystopia, the necessity to bear painful reality, within or without, is interpreted as a failure of the socio-economic system, and pain is treated as an emergent contingency which must be dealt with by extraordinary interventions.*<sup>11</sup>

Canadian philosopher Charles Taylor was moved to reflect further on the cultural shift that has systematically devalued and disposed of traditional ways of dealing with the experience of birth and death, of health and disease, and of sickness and suffering in much of the Western world:

*So medicalisation alters our phenomenology of lived experience. . . We don't see that we are being led to see/feel ourselves in different ways, we just believe naively that this is experience itself; we imagine*

<sup>9</sup> Ivan Illich (1976): *Limits to Medicine; Medical Nemesis: The Expropriation of Health*, Marion Boyers Publishers, London, p. 169

<sup>10</sup> *Ibid.*, p. 79

<sup>11</sup> *Ibid.*, pp. 135-136

*that people have always imagined themselves this way. And we are baffled by accounts of earlier ages.*<sup>12</sup>

Canadian broadcaster and long-time friend of Ivan Illich, David Cayley recently offered a penetrating critique of how Western governments have handled Covid-19 according to the frame presented by Ivan Illich in both his *Limits to Medicine* and his earlier published *Tools for Conviviality*. In it, Cayley succinctly outlines Illich's understanding of cultural iatrogenesis:

*Cultural iatrogenesis . . . occurs . . . when cultural abilities, built up and passed on over many generations, are first undermined, and then, gradually, replaced altogether. These abilities include, above all, the willingness to suffer and bear one's own reality, and the capacity to die one's own death.*<sup>13</sup>

According to Cayley, the Western response to Covid-19 represents a quintessential expression of how biomedicine has appropriated political, social and cultural authority in a manner anticipated by Illich nearly half a century ago: "Illich's perspective indicates that for some time now we've been practicing the attitudes that have characterized the response to the current pandemic."<sup>14</sup> Illich's early cautions addressed the progressive loss of community, autonomy, and self-reliance that were increasingly evident in the shadow of unrestrained technological growth and power. Cayley concludes: "There is no doubt that the world Illich warned of has come to pass."<sup>15</sup>

*Medical Nemesis* is too dense and too difficult a work to be circumscribed by any short review. A few months before Illich's death in December 2002 however, Richard Smith, editor of the *British Medical Journal* reflected on his own re-reading of Illich's *Medical Nemesis*, a work that had profoundly influenced him as an undergraduate in the 1970s. He concluded his own review with the following remark:

*"It's the ultimate book reviewer's cliché to say that every doctor and medical student should read this book, but those who haven't have missed something really important. When sick I want to be cared for by doctors who every day doubt the value and wisdom of what they do – and this book will help make such doctors."*<sup>16</sup>

Illich is to be admired for his principled courage and fearless confrontation of forces he perceived as being inherently damaging to the individual soul and the collective psyche. Illich lived according to what he spoke and what he wrote. Even in the end, he eschewed the ministrations of oncologists in the treatment of a disfiguring facial tumour that seared his later years, preferring to wear both the pain and the tumour with fortitude and dignity. He remained active until the end, finding occasional ease by lighting a small piece of opium in the pipe that he carried about with him.

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<sup>12</sup> Charles Taylor, op. cit., p. 740

<sup>13</sup> David Cayley (April 2020): *Questions About the Current Pandemic from the Point of View of Ivan Illich*, p. 3. Available in PDF form at: <https://archive.org/details/cayley-coronavirus-illich-en>

<sup>14</sup> Ibid., p. 11

<sup>15</sup> Ibid., p. 16

<sup>16</sup> Smith, Richard (2002) "Book Review, *Limits to Medicine. Medical Nemesis: The Expropriation of Health*, BMJ, 324, 13th April. Viewed at: <http://www.bmj.com/content/324/7342/923.1>

There is more that could be said, but this is sufficient to give some sense of the systemic nature of Illich's critique. He was not interested in patchwork solutions, but along with his contemporary brothers-in-arms Fritz Schumacher and Leopold Kohr, Ivan Illich sought to alert all who would hear that Western civilisation had entered very dangerous and destructive times.



## **IVAN ILLICH (1976): *Limits to Medicine; Medical Nemesis: The Expropriation of Health*, Marion Boyars Publishers, London**

### **Selected Excerpts**

#### **Introduction**

The layman in medicine, for whom this book is written, will himself have to acquire the competence to evaluate the impact of medicine on health care. Among all our contemporary experts, physicians are those trained to the highest level of specialized incompetence for this urgently needed pursuit. p. 6

#### **The Epidemics of Modern Medicine**

What had formerly been considered an abuse of confidence and a moral fault can now be rationalized into the occasional breakdown of equipment of operators. In a complex technological hospital, negligence becomes “random human error” or “system breakdown”, callousness becomes “scientific detachment”, and incompetence becomes “a lack of specialized equipment”. The depersonalization of diagnosis and therapy has changed malpractice from an ethical into a technical problem. p. 30

The so-called health professions have an even deeper, culturally health-denying effect insofar as they destroy the potential of people to deal with their human weakness, vulnerability, and uniqueness in a personal and autonomous way. The patient in the grip of contemporary medicine is but one instance of mankind in the grip of its pernicious techniques. This cultural iatrogenesis . . . is the ultimate backlash of hygienic progress and consists in the paralysis of healthy responses to suffering, impairment, and death. It occurs when people accept health management designed on the engineering model, when they conspire in an attempt to produce, as if it were a commodity, something called “better health.” This inevitably results in the managed maintenance of life on high levels of sublethal illness. This ultimate evil of medical “progress” must be clearly distinguished from both clinical and social iatrogenesis. pp. 33-34

#### **The Medicalization of Life**

Social iatrogenesis is at work when health care is turned into a standardized item, a staple; when all suffering is “hospitalised” and homes become inhospitable to birth, sickness, and death; when the language in which people could experience their bodies is turned into bureaucratic gobbledegook; or when suffering, mourning, and healing outside the patient role are labelled a form of deviance. p. 41

When hospitals draft all those who are in critical condition, they impose on society a new form of dying. p. 42

The divorce between medicine and morality has been defended on the ground that medical categories, unlike those of law and religion, rest on scientific foundations exempt from moral evaluation. p. 47

The fundamental reason why these costly bureaucracies are health-denying lies not in their instrumental but in their symbolic function: they all stress delivery of repair and maintenance services for the human component of the megamachine, and criticism that proposes better and more equitable delivery only reinforces the social commitment to keep people at work in sickening jobs.

p. 61

Powerful medical drugs easily destroy the historically rooted pattern that fits each culture to its poisons; they usually cause more damage than profit to health, and ultimately establish a new attitude in which the body is perceived as a machine run by mechanical and manipulating switches.

p. 63

One doctor in Latin America who was also a statesman did try to stem the pharmaceutical invasion rather than just enlist physicians to make it look more respectable. During his short tenure as president of Chile, Dr. Salvador Allende quite successfully mobilized the poor to identify their own health needs and much less successfully compelled the medical profession to serve basic rather than profitable needs. He proposed to ban drugs unless they had been tried on paying clients in North America or Europe for as long as the patent protection would run. He revived a program aimed at reducing the national pharmacopoeia to a few dozen items, more or less the same as those carried by the Chinese barefoot doctor in his black wicker box. Notably, within one week after the Chilean military junta took power on September 11, 1973, many of the most outspoken proponents of a Chilean medicine based on community action rather than on drug imports and drug consumption had been murdered.

pp. 68-69

The age of new drugs began with aspirin in 1899. Before that time, the doctor himself was without dispute the most important therapeutic agent.

p. 74



The hospital, the modern cathedral, lords it over this hieratic environment of health devotees. From Stockholm to Wichita the towers of the medical center impress on the landscape the promise of a conspicuous final embrace. For rich and poor, life is turned into a pilgrimage through check-ups and clinics back to the ward where it started. Life is thus reduced to a “span,” to a statistical phenomenon which, for better or for worse, must be institutionally planned and shaped. This life-span is

brought into existence with the prenatal check-up, when the doctor decides if and how the foetus shall be born, and will end with a mark on a chart ordering resuscitation suspended. Between delivery and termination this bundle of biomedical care fits best into a city that is built like a mechanical womb. At each stage of their lives people are age-specifically disabled. The old are the most obvious example: they are victims of treatments meted out for an incurable condition.

p. 79

Only the very rich and the very independent can choose to avoid that medicalization of the end to which the poor must submit and which becomes increasingly intense and universal as the society they live in becomes richer.

p. 84

By turning the newborn into a hospitalized patient until he or she is certified as healthy, and by defining grandmother's complaint as a need for treatment rather than for patient respect, the medical enterprise creates not only biologically formulated legitimacy for man the consumer but

also new pressures for an escalation of the megamachine. Genetic selection of those who fit into that machine is the logical next step of medico-social control. p. 88

The doctor's refusal to recognize the point at which he has ceased to be useful as a healer and to withdraw when death shows on his patient's face has made him into an agent of evasion or outright dissimulation. The patient's unwillingness to die on his own makes him pathetically dependent. He has now lost his faith in his ability to die, the terminal shape that health can take, and has made the right to be professionally killed into a major issue. pp. 102-103

In high culture, religious medicine is something quite distinct from magic. The major religions reinforce resignation to misfortune and offer a rationale, a style, and a community setting in which suffering can become a dignified performance. The opportunities offered by the acceptance of suffering can be differently explained in each of the great traditions: as karma accumulated through past incarnations; as an invitation to Islam, the surrender to God; or as an opportunity for closer association with the Saviour on the Cross. High religion stimulates personal responsibility for healing, sends ministers for sometimes pompous and sometimes effective consolation, provides saints as models, and usually provides a framework for the practice of folk medicine. In our kind of secular society religious organizations are left with only a small part of their former ritual healing roles. One devout Catholic might derive intimate strength from personal prayer, some marginal groups of recent arrivals in Sao Paulo might routinely heal their ulcers in Afro-Latin dance cults, and Indians in the valley of the Ganges still seek health in the singing of the Vedas. But such things have only a remote parallel in societies beyond a certain per capita GNP. In these industrialized societies secular institutions run the major myth-making ceremonies. pp.108-109

Medical procedures turn into black magic when, instead of mobilizing his self-healing powers, they transform the sick man into a limp and mystified voyeur of his own treatment. Medical procedures turn into sick religion when they are performed as rituals that focus the entire expectation of the sick on science and its functionaries instead of encouraging them to seek a poetic interpretation of their predicament or find an admirable example in some person - long dead or next door - who learned to suffer. Medical procedures multiply disease by moral degradation when they isolate the sick in a professional environment rather than providing society with the motives and disciplines that increase social tolerance for the troubled. Magical havoc, religious injury, and moral degradation generated under the pretext of a biomedical pursuit are all crucial mechanisms contributing to social iatrogenesis. pp. 114-115

More and more people subconsciously know that they are sick and tired of their jobs and of their leisure passivities, but they want to hear the lie that physical illness relieves them of social and political responsibilities. They want their doctor to act as lawyer and priest. As a lawyer, the doctor exempts the patient from his normal duties and enables him to cash in on the insurance fund he was forced to build. As a priest, he becomes the patient's accomplice in creating the myth that he is an innocent victim of biological mechanisms rather than a lazy, greedy, or envious deserter of a social struggle for control over the tools of production. p. 123

### **Cultural iatrogenesis**

Professionally organized medicine has come to function as a domineering moral enterprise that advertises industrial expansion as a way against all suffering. It has thereby undermined the

ability of individuals to face their reality, to express their own values, and to accept inevitable and often irremediable pain and impairment, decline, and death. pp. 127-128

Most healing is a traditional way of consoling, caring, and comforting people while they heal, and most sick-care a form of tolerance extended to the afflicted. Only those cultures survive that provide a viable code that is adapted to a group's genetic make-up, to its history, to its environment, and to the peculiar challenges represented by competing groups of neighbors. p. 131



Traditional cultures and technological civilization start from opposite assumptions. In every traditional culture the psychotherapy, belief systems, and drugs needed to withstand most pain are built into everyday behavior and reflect the conviction that reality is harsh and death inevitable. In the twentieth century dystopia, the necessity to bear painful reality, within or without, is interpreted as a failure of the socio-economic system, and pain is treated as an emergent contingency which must be dealt with by extraordinary interventions. pp. 135-136

While rejecting an acceptance of suffering as a form of masochism, anaesthesia consumers tend to seek a sense of reality in ever stronger sensations. They tend to seek meaning for their lives and power over others by enduring undiagnosable pains and unrelievable anxieties: the hectic life of business executives, the self-punishment of the rat-race, and the intense exposure to violence and sadism in films and on television. In such a society the advocacy of a renewed style in the art of suffering that incorporates the competent use of new techniques will inevitably be misinterpreted as a sick desire for pain: as obscurantism, romanticism, dolorism, or sadism. pp. 152-153

The sufferings for which traditional cultures have evolved endurance sometimes generated unbearable anguish, tortured imprecations, and maddening blasphemies; they were also self-limiting. The new experience that has replaced dignified suffering is artificially prolonged, opaque, depersonalized maintenance. Increasingly, pain-killing turns people into unfeeling spectators of their own decaying selves. p. 154



The age of hospital medicine, which from rise to fall lasted no more than a century and a half, is coming to an end. Clinical measurement has been diffused throughout society. Society has become a clinic, and all citizens have become patients whose blood pressure is constantly being watched and regulated to fall “within” normal limits. The acute problems of manpower, money, access, and control that beset hospitals everywhere can be interpreted as symptoms of a new crisis in the concept of disease. This is a true crisis because it admits of two opposing solutions, both of which make present hospitals obsolete. The first solution is a further sickening medicalization of health care, expanding still further the clinical control of the medical profession over the ambulatory population. The second is a critical, scientifically sound demedicalization of the concept of disease. pp. 165-166

An advanced industrial society is sick-making because it disables people from coping with their environment and, when they break down, from substituting a “clinical” prosthesis for the

broken relationships. People would rebel against such an environment if medicine did not explain their biological disorientation as a defect in their health, rather than as defect in the way of life which is imposed on them or which they impose on themselves. p. 169

The physician, himself a member of the dominating class, judges that the individual does not fit into an environment that has been engineered and is administered by other professionals, instead of accusing his colleagues of creating environments into which the human organism cannot fit. p. 169

### The Politics of Health

The aged are an example of the specialization of poverty which the overspecialization of services can bring forth. The elderly in the United States are only one extreme example of suffering promoted by high-cost deprivation. Having learned to consider old age akin to disease, they have developed unlimited economic needs in order to pay for interminable therapies, which are usually ineffective, are frequently demeaning and painful, and call more often than not for seclusion in a special milieu. p. 219

The World Health Organization, meanwhile, is moving to a conclusion that would have shocked most of its founders: in a recent publication WHO advocates the deprofessionalization of primary care as the most important single step in raising national health levels. p. 227

The person who, upon the diagnosis of cancer, chooses an operation over a binge in the Bahamas does not know what effect his choice will have on his remaining time of grace. The economics of health is a curious discipline, somewhat reminiscent of the theology of indulgences which flourished before Luther. You can count what the friars collect, you can look at the temples they build, you can take part in the liturgies they indulge in, but you can only guess what the traffic in remission from purgatory does to the soul after death. Models developed to account for the willingness of taxpayers to foot rising medical bills constitute similar scholastic guesswork about the new world-spanning church of medicine. pp. 231-233

The deprofessionalization of medicine does not imply the proscription of technical language any more than it calls for the exclusion of genuine competence, nor does it oppose public scrutiny and exposure of malpractice. But it does imply a bias against the mystification of the public, against the mutual accreditation of self-appointed healers, against the public support of a medical guild and of its institutions, and against the legal discrimination by, and on behalf of, people whom individuals or communities choose and appoint as their healers. . . The proposal that doctors not be licensed by an in-group does not mean that their services shall not be evaluated, but rather that this evaluation can be done more effectively by informed clients than by their own peers. . . .

Deprofessionalization of medicine means the unmasking of the myth according to which technical progress demands the solution of human problems by the application of scientific principles, the myth of benefit through an increase in the specialization of labor, through multiplication of arcane manipulations, and the myth that increasing dependence of people on the right of access to impersonal institutions is better than trust in one another. pp. 255-256

Better health care will depend, not on some new therapeutic standard, but on the level of willingness and competence to engage in self-care. p. 270

Increasing and irreparable damage accompanies present industrial expansion in all sectors. In medicine this damage appears as iatrogenesis. Iatrogenesis is clinical when pain, sickness, and death result from medical care; it is social when health policies reinforce an industrial organization that generates ill-health; it is cultural and symbolic when medically sponsored behavior and delusions restrict the vital autonomy of people by undermining their competence in growing up, caring for each other, and aging, or when medical intervention cripples personal responses to pain, disability, impairment, anguish, and death. 270-271

Health is a task, and as such is not comparable to the physiological balance of beasts. Success in this personal task is in large part the result of the self-awareness, self-discipline, and inner resources by which each person regulates his own daily rhythm and actions, his diet, and his sexual activity. Knowledge encompassing desirable activities, competent performance, the commitment to enhance health in others - these are all learned from the example of peers or elders. These personal activities are shaped and conditioned by the culture in which the individual grows up. pp 273-274

